BIOMEDICAL IMAGING CENTER
OSU Medicine

MRI BREAST PATIENT INFORMATION WORKSHEET

Patient Name _____ Date of Exam:_____

Date of Birth: _____

Have you had a breast exam by a Doctor, PA or Nurse Practitioner in the last 12 months? YES NO

Have you had a previous Mammogram? YES NO

If yes, where was your last Mammogram?
_____Year_____

Han you had a breast MRI? YES NO

If yes, where and when?_____

CURRENT BREAST SYMPTOMS

(Circle the symptoms in this section that apply)

Lump or thickening: R L BOTH
Lump felt by: Doctor Self
Pain/tenderness: R L BOTH
Nipple discharge: R L BOTH
Discharge color:_____
Nipple abnormality: R L BOTH
Lymph node under arm: R L BOTH
Infection/Inflammation: R L BOTH
Skin changes R L BOTH
Recent Breast Injury: R L BOTH
Implant problem: R L BOTH
Comments:_____
_____

BREAST HISTORY/SURGERY

Have you had any previous breast surgery/biopsy?
YES NO
(if YES, circle or check all in this section that apply)

Breast Biopsy: R L AGE_____
Was it cancer? YES NO
Lumpectomy? R L AGE_____
Was it cancer? YES NO
Cyst Aspiration: R L AGE_____
Implants: R L AGE_____
_____Saline _____Silicone
Breast Reduction: R L AGE_____
Breast Lift R L AGE_____
Breast Cancer: R L AGE_____
Mastectomy: R L AGE_____
Reconstruction? YES NO
___Flap ____Implant ____Tissue
Radiation therapy? YES NO
Date completed?_____
Chemotherapy? YES NO
Are you takin tamoxifen/other type CA meds?
YES NO

PATIENT SIGNATURE:_____
DATE:_____

FAMILY HISTORY OF BREAST CANCER

Has any blood relative had breast Cancer? YES NO

			AGE AT DIAGNOSIS
MOTHER:	**YES**	**NO**	**_____**
SISTER:	**YES**	**NO**	**_____**
DAUGHTER:	**YES**	**NO**	**_____**
GRANDMOTHER:	**maternal**	**paternal**	**_____**
AUNT:	**maternal**	**paternal**	**_____**

OTHER FAMILY MEMBER: WHO? _____ AGE _____
MALE FAMILY MEMBER: WHO? _____AGE _____
Family History Unknown [ ]

GYNECOLOGICAL HISTORY

Are you pregnant? YES____ NO____
Age at first menstrual cycle:_____
Date of last menstrual cycle: _____(first day)
How many children did you have:_____
Your age at first live birth:_____
Did you breastfeed? YES____ NO____
Are you currently breastfeeding? YES ____NO____
Menopause: YES____ NO___ AGE_____
Are you currently taking hormones? YES____NO____
If YES, for how long?_____ stopped_____
Have you taken hormones in the past: YES___ NO____
If YES, for how long?_____
Hysterectomy: YES_____NO_____ AGE_____
Were your ovaries removed? YES___NO___ RT__ LT___
Do you have BRCA gene? YES___NO___UNKNOWN_____
Personal history of ovarian cancer? YES____NO____
Family history of ovarian cancer? YES____ NO____
If YES, who?_____

DO NOT WRITE BELOW

TECHNOLOGIST SECTION ONLY

REASON FOR MRI

____Pre-surgical evaluation
____High risk screening
____Personal history of treated breast cancer
____History of high risk lesion _____type
____Genetic predisposition (BRCA)
____Clinical concern _____type
____Previous abnormality (mammography or Ultrasound)
____Response to Chemotherapy
____Short term follow up MRI Bx
____Rule out implant rupture

Contrast type_____Amount given_____
Tech _____Date_____